CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/28/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155650	A. BUILDING	00	COMPLETED 06/07/2011
		100000	B. WING		00/07/2011
NAME OF F	ROVIDER OR SUPPLIER		l l	ADDRESS, CITY, STATE, ZIP CODE	
LINCOLN	ISHIRE HEALTH CA	ARE CENTER		IRGINIA ST LLVILLE, IN46410	
		TATEMENT OF DEFICIENCIES	ID ID		(V.5)
(X4) ID PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
F0000					
			1		
		r the Investigation of	F0000		
	Complaint IN000	090935.			
	•	090935- Substantiated,			
		ciencies related to the			
		ted at F 225, F 226, F			
	282, and F 385.				
	Survey dates: Ju	no 6 and 7, 2011			
	Survey dates. Ju	ile 0 and 7, 2011			
	Facility number:	000577			
	Provider number				
	AIM number: 10				
	1 111/1 11/1110 01.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
	Survey team:				
	Janelyn Kulik, R	N, TC			
	Janet Adams, RN				
	(June 6, 2011)				
	Census bed type:				
	SNF/NF: 80				
	Total: 80				
	Census payor typ	e:			
	Medicare: 18				
	Medicaid: 55				
	Other: 7				
	Total: 80				
	G 1 0				
	Sample: 9				
	There D. C	on also meffect City			
	i nese Deficienci	es also reflect State			
LABORATOR	Y DIRECTOR'S OR PROV	TDER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6L0E11

Facility ID:

000577

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155650			(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY  COMPLETED  06/07/2011
	PROVIDER OR SUPPLIER		STREET A 8380 V	ADDRESS, CITY, STATE, ZIP CODE IRGINIA ST LLVILLE, IN46410	-1
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION
	findings cited in 16.2.	accordance with 410 IAC			
	Quality review c 2011 by Bev Fau	ompleted on June 10, alkner, RN			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPL	ETED
		155650	B. WING			06/07/2	011
			B. WING		DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				RGINIA ST		
LINCOLN	ISHIRE HEALTH CA	ARE CENTER			LVILLE, IN46410		
(X4) ID	ID SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
F0225 SS=D	have been found of or mistreating residence had a finding nurse aide registry mistreatment of residence of their property; a has of actions by a employee, which we service as a nurse	ot employ individuals who guilty of abusing, neglecting, dents by a court of law; or gentered into the State or concerning abuse, neglect, sidents or misappropriation and report any knowledge it a court of law against an avould indicate unfitness for a aide or other facility staff to de registry or licensing					
	violations involving abuse, including ir and misappropriat reported immediat the facility and to d with State law thro	nsure that all alleged g mistreatment, neglect, or njuries of unknown source ion of resident property are ely to the administrator of other officials in accordance ough established procedures tate survey and certification					
	alleged violations	ave evidence that all are thoroughly investigated, further potential abuse while in progress.					
	reported to the addrepresentative and accordance with S State survey and oworking days of the	nvestigations must be ministrator or his designated of to other officials in state law (including to the certification agency) within 5 e incident, and if the alleged appropriate corrective sen.					
	facility failed to abuse was report	review and interview, the ensure an allegation of ed promptly to the d the alleged staff	F02	225	- 1. Residenti#H was assessed physical and emotional injury, non notied		07/07/2011
	member was rem	loved form resident care			noucu		

STATEMENT OF DEFICIENCIES X1) PROVI		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	LETED
		155650	B. WIN			06/07/2	011
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	· ·		8380 VI	RGINIA ST		
	LINCOLNSHIRE HEALTH CARE CENTER			MERRII	LLVILLE, IN46410		
(X4) ID		STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DEFICIENCY)			(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL				ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENC!)		DATE
	1	tion of the investigation			As stiatied in tih€567, CNA #1 wa	c	
	_	of abuse for 1 of 3			suspended upon being notiffed o		
		ed for allegations of			abuse allegation on 4/18/11, and		
	_	e of 9. (Resident #H and			investigation was conductied CN		
	CNA #1)				#1 was re-educatied on abuse an		
					custiomer service prior tio retiurr	ning	
	Findings include:				tio work ati conclusion off		
					investigation.		
	Review of a reportable incident provided by the Director of Nursing (DoN) and				LPN #1 and LPN #2 were re-educa		
					on 4/19/11 regarding immediatie		
	1 -	7/11 at 11:00 a.m.,			reporting off abuse allegations tic Administiration	tine	
		te of the incident was			Administration		
	4/16/11.						
	Brief description	of the incident:			<ol><li>All abuse allegation report</li></ol>	is	
	_	name) reported to her			since 4/1/11 have been reviewed	tio	
	,	aring for her on her last			identiffy any otiher potiential def	fcienti	
		_			practices in timely notiffcation, ar		
	1	ch was 4-16-2011 that her			no ffurtiher issues were identiffe	d	
	`	name) was mean and			2 In comics ffor all sticfform	_	
	_	ner clothes to her and she			<ol><li>In-service ffor all stiaff was completied on4/21/11 and 4/22/</li></ol>		
	l "	All this was stated to			regarding abuse allegations and t		
		uring her shower. Writer			immediatie reporting off abuse		
	`	sident #H's name) and she			allegations tio tihe Administiratio	r	
		r last shower day her					
	CNA in which s	he could not remember			The Administiratior or designee w	/ill	
	her name, but di	d describe her as the one			auditi employee ffles tio identiffy		
	that wears the ja	cket around her waist all			stiaff who has noti received inserv		
	the time and and	(sic) acts funny			on abuse and reporting off abuse		
	(humorous) was	complaining about lifting			including all employees hired sind 1/1/11. All stiaff identiffed will	æ	
		at she was not going to			receive an in-service on abuse an	d	
	ruin her health lifting and kept going on about it. (Resident #H's name) stated that				abuse reporting by 7/7/11.	-	
					. 5,7.		
		g to the shower chair she			All new employees will receive ab	ouse	
		d missed the chair and the			tiraining during tihe ffrsti day off	new	
	· ·	by her right arm. She			employee orientiation and will		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155650 06/07/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8380 VIRGINIA ST LINCOLNSHIRE HEALTH CARE CENTER MERRILLVILLE, IN46410 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE also stated that the CNA would not give successffully completie a postiiesti tio ensure understianding off abuse and her clothes to her, and she took them out abuse reporting. of her hands and the other girl gave them back. (Resident #H's name) stated that The Administiratior or designee will her clothes are not labeled and she did not review all new employee ffles witihin want them to get lost. (Resident #H's 72 hours off orientiation class tio name) also stated that there was another ensure tihati abuse tiraining is resident in the shower room that heard completied on ffrsti day off new employee orientiation everything; and the CNA also stated that she have (sic) people working here. The Administiratiors cell phone (Resident #H's name) said that as they number has been postied in came out of the shower room, her and the designatied areas available ffor all CNA continue(sic) to argue. stiaff All abuse allegations will be reportied tio tihe Administirationhe Interviews were completed with other Administiratior will review all abuse staff members that worked that shift and allegations reportied immediatiely by no one gave statement as to hearing or tihe stiaff and ensure tihati tihe alleged seeing what happened besides one other stiaff members are removed ffrom CNA and she stated that she only heard residenti care until tihe completion off both sides of the story from (Resident tihe investigation off tihe abuse allegation. #H's name) and CNA (CNA #1's name), but could not be counted as a witness to The resultis off tihese ffndings the event. This writer interviewed the will be reviewed in tihe Qualitiy resident that was in the shower room at Assurance meeting montihly &, tihen the time of this incident, but she could not quartierly 2 tio ensure compliance remember anything that happened in there Compliance datie July 7, 2011 and stated that she was sorry that she could not help me." Immediate action taken: "Immediately after the shower was over according to (Resident #H's name) she went back to her room. Shortly after that (Resident #H's name) stated that's when she reported the incident to her nurse." Preventive measures taken: "The CNA

000577

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE (	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155650	B. WING		06/07/2011
NAME OF F	PROVIDER OR SUPPLIER		STREE	ADDRESS, CITY, STATE, ZIP CODE	
			l l	VIRGINIA ST	
LINCOLN	NSHIRE HEALTH C	ARE CENTER	MERF	RILLVILLE, IN46410	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	1 *	ded pending investigation			
	at this time."				
	A -4-4	4 1 I DNI #1 in diasta d			
		ten by LPN #1 indicated,			
		oril 16, 2011 at about			
	` * *	(Resident #H's name)			
	1 ^	fter leaving out (sic) the			
		A (CNA #1's name) was			
		to me. She pulled on my			
		an things to me. CNA			
	l '	) denied everything that			
		red 'Umm I got a witness,			
	1	here ask her.' That lady			
	`	's name) I asked her what			
	* *	d she her (sic) anything			
	she stated 'no, id	k (I don't know).' "			
	A statement write	ten by LPN #2 indicated			
		B wing on April 16, 2011.			
		wn at the nurse's station			
		pproached by (Resident			
		esident #H's name) asked			
	·	Il her daughter (daughter's			
		replied back sure and			
	l '	ter. After she completed			
	1	Resident #H's name)			
		I was the only person			
		e to her. She also stated			
		ff has been rough and			
		e she has been here. I			
		rse responsible for			
		ame) on 4/16/11 of her			
	l '	" This statement was			
	-	2 and dated 4/19/11.			
	signed by Li IV #	2 and dated 7/17/11.			

PRINTED: 06/28/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		Ì		ONSTRUCTION  00	(X3) DATE COMPL		
		155650	A. BUII			06/07/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				IRGINIA ST		
LINCOL	NSHIRE HEALTH CA	ARE CENTER		1	LLVILLE, IN46410		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	<b>A</b> i444 -4	ant altain al fram CNIA					
		ent obtained from CNA					
	l '	on as I came on the					
	. ` `	#H's name) stay (sic) on					
		nswered her call light, I					
	'1 0	ive me a minute. I just					
	~	let me get my things					
	-	I left the room she got  I want to get up, I said					
	1	things together, I left the					
	' ' '	sic) back on the light, I					
	· '	,					
	<u>-</u>	I said ok, let me get it e said I want to use the					
	"	ok, so what I did (sic) I					
	1	on (sic) took her to the					
	· '	c) her do you steel (sic)					
		athroom, she said yes,					
	1 ^	et (sic), then I put her in we finished the shower,					
	· ·						
	l ` ´ *	ig her off, that's (sic)					
	` ′	those scards (sic) on her					
		what happen (sic) to your					
	· •	head down and said, I					
	1	arms from the way she					
	` ' '	ve she didn't want to talk					
		(sic). I ment (sic) no ower, I was taking her					
		•					
		r room, she said I want old her no, because they					
	•	and I will not give you					
	1	ng, that's when she said					
	· ·	ng, that's when she said n her clothing, when me					
		<b>O</b> ,					
		of the shower room, she					
	yened out sne pu	lled my arms, she pulled					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6L0E11

Facility ID:

000577

If continuation sheet

Page 7 of 27

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  8380 VIRGINIA ST	
LINCOLNSHIRE HEALTH CARE CENTER  MERRILLVILLE, IN46410	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION  PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)	(X5) COMPLETION DATE
by arms. I couldn't believe she said this, I told the nurse, no that a (sic) lie. I would not never (sic) hurt these older people for the world, then I told the nurse I refuse to work with her for the rest of the day because I refuse to loose (sic) my job, over her lying on me, I wrote the paper on her first. (Resident #K's name) was satting (sic) beside me, when I was writing the paper out on her, for acking (sic) out and lying on (sic) me. So the nurse told me to trade people with her, everyone told me no way. It was my first time working with her. Now, I see why the other girls say they don't want to work with her, so I took (Resident #K's name) outside of her room. I told him I need you to help me, when I go in her room I will leave open, so you can here (sic) everything that's going on, because I am afraid I can loose (sic) my job, cause this lady will lie on you (sic). Oh yes I forgot I had help by (Resident #K's name) so that night she had come (sic) down, so I through (sic) the paper away. (Resident #K's name) seen me write the paper and he also seen me through (sic) it away, but I wrote her up first then I said forget it, she is better now."  Conclusion of events typed by the DoN, indicated "In conclusion writer received statement from alleged CNA (CNA #I's name) in regards to what occurred on the	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE :		
AND PLAN	OF CORRECTION	155650	A. BUII	LDING	00	06/07/2	
		133030	B. WIN			00/07/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE IRGINIA ST		
LINCOLN	NSHIRE HEALTH CA	ARE CENTER		1	LLVILLE, IN46410		
		TATEMENT OF DEFICIENCIES			,		(V5)
(X4) ID PREFIX		CY MUST BE PERCEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	day of (Resident	#H's name) shower. In					
	the statement (C)	NA #1's name) states that					
	· ` `	Resident #H's name)					
		H's name) became					
	. ` `	the transfer from the					
	wheelchair to the	shower chair and she					
	states that she he	ld (Resident #H's name)					
		at she would not fall and					
	helped her to sit i	in the chair. She also					
	stated that she as	ked (Resident #H's					
	name) about the	bilateral scars that are					
	located on her sh	oulders and (Resident					
	#H's name) stated	d in return that she had					
	broken both of he	er arms before. She said					
	that she did take	the clothes from					
	(Resident #H's na	ame) and she explained					
	to (Resident #H's	name) that the clothes					
	were dirty that w	as the only reason why					
	she was taking th	nem, but (Resident #H's					
	name) did not wa	ant her to and the nurse					
	told her to just gi	ve them back if that's					
	what she wanted.	(CNA #1's name) stated					
	that she was thin	king more on the side on					
	(sic) contaminati	ng the clean clothes that					
	(Resident #H's na	ame) had just put on after					
	her shower. (CN	(A #1's name) also stated					
	that she told (Res	sident #H's name) that					
	her daughter wor	ked here as well and she					
	never do (sic) an	ything to jeopardize her					
	job or any residen	nt. She stated that she					
	meant nothing ba	nd by telling (Resident					
	#H's name) that.						
	There was not (si	ic) abuse found to be					
	true. Three other	alert and oriented					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6L0E11

Facility ID:

000577

If continuation sheet

Page 9 of 27

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155650		(X2) MULTIPLE C  A. BUILDING  B. WING	ONSTRUCTION  00	COM	TE SURVEY  MPLETED  7/2011	
	PROVIDER OR SUPPLIER		STREET 8380 V	ADDRESS, CITY, STATE, ZIP /IRGINIA ST !ILLVILLE, IN46410	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	hall and none of complaints about received. The Crinformed that she care of the (sic) (CNA #1's name coaching regardi perceive things. provided to all or customer services.  The cover letter a indicated the infect to Indiana State 14/18/11.  The closed recorreviewed on 6/7/diagnoses includ to, heart failure, mellitus, bipolar, pulmonary disea.  A 14 day Minimum dated 4/21/11, in understood and coscored a 15 on the Mental Status who cognitively intact.  Interview with the a.m., indicated L.	the care that they have NA (CNA #1's name) was a would no longer take Resident #H's name). The received one on one ing how residents may an in-service was a the staff on abuse and the				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	IULTIPLE CO.	NSTRUCTION 00	COMPI		
THIE TEAM	or condition	155650	1	LDING		06/07/2	
		100000	B. WIN		DDDECC CITY CTATE ZID CODE	00/01/2	
NAME OF F	PROVIDER OR SUPPLIER			1	DDRESS, CITY, STATE, ZIP CODE RGINIA ST		
LINCOLN	ISHIRE HEALTH C	ARE CENTER		1	LVILLE, IN46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		she was not in the					
	shower room wh	ere the incident					
	happened.						
	Interview with th	ne DoN on 6/7/11 at					
	12:45 p.m., indic	cated LPN #1 and LPN #2					
	-	of the allegations on the					
		nt. The DoN further					
	-	s not made aware of the					
		he returned to the facility					
	_	also verified that CNA					
	#1 was not sent h	nome on 4/16/11, the day					
	the allegation wa	•					
	_	ng the investigation on					
		n indicated that LPN #1					
		not contacted her when					
		s made because they did					
	_	as what they were to do in					
		llegation of abuse.					
	Interview with th	ne DoN on 6/7/11 at 2:30					
	p.m., indicated sl	he immediately informs					
	•	r when she receives an					
	allegation of abu						
	_						
	_	elates to Complaint					
	IN00090935.						
	3.1-13(g)(1)						
	3.1-28(d)						
	3.1 20(d)						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETE.			ETED	
		155650	B. WIN			06/07/20	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				IRGINIA ST		
LINCOLN	ISHIRE HEALTH CA	ARE CENTER			LLVILLE, IN46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROVIDERIC DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	<sub></sub>	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0226 SS=D	The facility must d written policies and mistreatment, negland misappropriate Based on record facility failed to a followed its abust reporting all alleg immediately to the Director of Nursistaff member whallegations of abuthe completion of 3 residents revaluse in a sample CNA#1)  Findings include  The Abuse, Neglanding Misappropriation was provided by	evelop and implement d procedures that prohibit lect, and abuse of residents ion of resident property. The review and interview, the ensure the facility staff e policy regarding gations of abuse the Administrator or the long (DoN) and removing to have been accused of lase for the facility until for the investigation for 1 riewed for allegations of e of 9. (Resident #H and lo of Resident Property the Administrator on m. The policy indicated,	F0	226	F226  1. Residenti#H was assessed to physical and emotional injury, nor notied  As stiatied in tih@567, CNA #1 was suspended upon being notiffed of abuse allegation on 4/18/11, and investigation was conductied CNA #1 was re-educatied on abuse and custiomer service prior tio retiurnatio work ati conclusion off investigation.  LPN #1 and LPN #2 were re-education on 4/19/11 regarding immediatie reporting off abuse allegations tio Administratior  2. All abuse allegation reportions since 4/1/11 have been reviewed identiffy any other potiential definance in timely notification, and	ne  if  ing  tied  tihe  is  tio  cienti	07/07/2011
	_	streatment, neglect or			no ffurtiher issues were identiffed		
		injuries of unknown			3. In-service ffor all stiaff was		
		ted immediately to the			completied on4/21/11 and 4/22/1	11	
		the facility and to other			regarding abuse allegations and til	he	
	officials in accord	dance with state law			immediatie reporting off abuse		
	through establish	ed procedures."			allegations tio tihe Administiratior		
	or employee is a	ins injury by an employee suspected perpetrator: I. loyee immediately. ii.			The Administiratior or designee w auditi employee ffles tio identiffy a stiaff who has noti received inserv on abuse and reporting off abuse including all employees hired since	any ice	

000577

<b>l</b> i '		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155650	B. WIN	IG		06/07/2011
NAME OF I	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
				1	IRGINIA ST	
LINCOL	NSHIRE HEALTH CA	ARE CENTER		MERRII	LLVILLE, IN46410	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	1	immediate supervisor			1/1/11. All stiaff identiffed will	.
		st conduct interview with			receive an in-service on abuse and abuse reporting by 7/7/11.	'
		sident. iii. Employee			abuse reporting by 7/7/11.	
	must be sent hom				All new employees will receive abo	use
		ding outcome of final			tiraining during tihe ffrsti day off n	
	investigation. iv.	Administrator must be			employee orientiation and will	
	notified immedia	tely of situation, and			successffully completie a postiesti	tio
	he/she must cond	luct an investigation			ensure understianding off abuse a	nd
	immediately."				abuse reporting.	
					The Administiratior or designee w	
	Review of a reportable incident provided				review all new employee ffles witi	
	by the Director of Nursing (DoN) and				72 hours off orientiation class tio	
	reviewed on 6/7/11 at 11:00 a.m.,				ensure tihati abuse tiraining is	
		e of the incident was			completied on ffrsti day off new	
	4/16/11.				employee orientiation	
	Brief description	of the incident:				
	_	name) reported to her			The Administrations call phone	
	`	ring for her on her last			The Administiratiors cell phone number has been postied in	
		h was 4-16-2011 that her				
	· ·	name) was mean and			designatied areas available ffor all stiaff All abuse allegations will be	
	,	er clothes to her and she			reportied tio tihe Administirationhe	
		All this was stated to			Administiratior will review all abus	se l
	l *				allegations reportied immediatiely	· I
		ring her shower. Writer			tihe stiaff and ensure tihati tihe all	-
	`	ident #H's name) and she			stiaff members are removed ffrom	
		last shower day her			residenti care until tihe completion tihe investigation off tihe abuse	II OII
		e could not remember			allegation.	
	· ·	I describe her as the one				
	ı	eket around her waist all				
	the time and and	-			4. The resultis off tihese ffndi	ngs
	(humorous) was	complaining about lifting			will be reviewed in tihe Qualitiy	
	her and stated that	nt she was not going to			Assurance meeting montihly &, til	
	ruin her health lit	fting and kept going on			quartierly 🛭 tio ensure compliance	
	about it. (Reside	nt #H's name) stated that			E Compliance detic luly 7.39	111
	while transferring	g to the shower chair she			5. Compliance datie July 7, 2	J11

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE COMPL		
AND PLAN	OF CORRECTION	155650	A. BUII	LDING	00	06/07/2	
		133030	B. WIN			00/07/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE IRGINIA ST		
LINCOLN	NSHIRE HEALTH CA	ARF CENTER		1	LLVILLE, IN46410		
		TATEMENT OF DEFICIENCIES		ID	,		(V5)
(X4) ID PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	was unsteady and	d missed the chair and the	i				
		by her right arm. She					
	l ř	ne CNA would not give					
		r, and she took them out					
		the other girl gave them					
		#H's name) stated that					
	her clothes are no	ot labeled and she did not					
	want them to get	lost. (Resident #H's					
	I -	I that there was another					
	resident in the sh	ower room that heard					
	everything; and t	he CNA also stated that					
	l	ople working here.					
	(Resident #H's na	ame) said that as they					
	came out of the s	hower room, her and the					
	CNA continue(si	c) to argue.					
	Interviews were	completed with other					
	staff members that	at worked that shift and					
	no one gave state	ement as to hearing or					
	seeing what happ	pened besides one other					
	CNA and she star	ted that she only heard					
	both sides of the	story from (Resident					
	#H's name) and (	CNA (CNA #1's name),					
	but could not be	counted as a witness to					
	the event. This v	vriter interviewed the					
	resident that was	in the shower room at					
	the time of this in	ncident, but she could not					
	remember anythi	ng that happened in there					
	and stated that sh	ne was sorry that she					
	could not help m	e."					
	Immediate action	n taken: "Immediately					
	after the shower	was over according to					
	(Resident #H's na	ame) she went back to					
	her room. Shortl	y after that (Resident					
	#H's name) stated	d that's when she reported					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	00	COMPL	
		155650	B. WING			06/07/2	011
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>	ST	TREET A	DDRESS, CITY, STATE, ZIP CODE		
			I		RGINIA ST		
LINCOL	NSHIRE HEALTH C	ARE CENTER	M	1ERRIL	LLVILLE, IN46410		
(X4) ID		STATEMENT OF DEFICIENCIES	П	- 1	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	CY MUST BE PERCEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG	<b>+</b>	LSC IDENTIFYING INFORMATION)	17	AG	DEFICIENC!)		DATE
	the incident to he						
		ures taken: "The CNA					
		ded pending investigation					
	at this time."						
		4-m 1 I DNI #1 1					
		ten by LPN #1 indicated,					
		oril 16, 2011 at about					
		(Resident #H's name)					
		fter leaving out (sic) the					
		A (CNA #1's name) was					
	1 -	to me. She pulled on my					
		an things to me. CNA					
	`	) denied everything that					
		ted "Umm I got a witness,					
	1	here ask her." That lady					
	`	I's name) I asked her what					
		d she her (sic) anything					
	she stated 'no, id	k (I don't know).' "					
	A statement writ	ten by LPN #2 indicated					
		B wing on April 16, 2011.					
		wn at the nurse's station					
	1	pproached by (Resident					
		esident #H's name) asked					
		ll her daughter (daughter's					
		replied back sure and					
		ter. After she completed					
	_	Resident #H's name)					
		I was the only person					
		e to her. She also stated					
		ff has been rough and					
	mean to her since she has been here. I						
		se responsible for					
		ame) on 4/16/11 of her					
		•					

PRINTED: 06/28/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
AND PLAN	OF CORRECTION	155650	1	LDING	00	06/07/2	
		133030	B. WIN			00/01/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
LINCOLN	NSHIRE HEALTH CA	ARE CENTER		1	LLVILLE, IN46410		
		TATEMENT OF DEFICIENCIES	_				(V.5)
(X4) ID PREFIX		CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	allegation to me.	" This statement was					
	signed by LPN #	2 and dated 4/19/11.					
	A written stateme	ent obtained from CNA					
	#1 indicated, "So	on as I came on the					
	floor, (Resident #	#H's name) stay (sic) on					
	her call light, I as	nswered her call light, I					
	told her, please g	give me a minute. I just					
	got on the floor,	let me get my things					
	together, soon as	I left the room she got					
	back on her light	. I want to get up, I said					
	ok, let me get my	things together, I left the					
	room, she were (	sic) back on the light, I					
	· -	I said ok, let me get it					
	-	e said I want to use the					
		ok, so what I did (sic) I					
	1 - 1	on (sic) took her to the					
	,	e) her do you steel (sic)					
		athroom, she said yes,					
	_	et (sic), then I put her in					
	· ·	n we finished the shower,					
	l ` ´ *	ng her off, that's (sic)					
	\ ′	those scards (sic) on her					
	l ' '	what happen (sic) to your					
	_	head down and said, I					
	· ·	arms from the way she					
	· · ·	eve she didn't want to talk					
		(sic). I ment (sic) no					
		ower, I was taking her					
		r room, she said I want					
	'	old her no, because they					
	-	g, and I will not give you					
	· -	ng, that's when she said					
	ner name is not i	n her clothing, when me					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6L0E11

Facility ID:

000577

If continuation sheet

Page 16 of 27

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155650		(X2) MULTIPLE CO  A. BUILDING  B. WING	00		E SURVEY PLETED /2011
	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CO IRGINIA ST LLVILLE, IN46410	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	yelled out she put by arms. I could told the nurse, no not never (sic) he the world, then I work with her for because I refuse over her lying on her first. (Reside (sic) beside me, yeaper out on her, lying on (sic) me trade people with no way. It was no with her. Now, I say they don't way took (Resident ### room. I told him when I go in her so you can here (going on, becaus (sic) my job, cau you (sic). Oh ye (Resident #K's not had come (sic) do the paper away, seen me write the me through (sic) up first then I sai now."	cof the shower room, she lled my arms, she pulled n't believe she said this, I to that a (sic) lie. I would art these older people for told the nurse I refuse to refuse to the rest of the day to loose (sic) my job, ame, I wrote the paper on the #K's name) was satting when I was writing the for acking (sic) out and and a so the nurse told me to the her, everyone told me my first time working asee why the other girls and to work with her, so I K's name) outside of her I need you to help me, room I will leave open, sic) everything that's e I am afraid I can loose see this lady will lie on so I forgot I had help by the ame) so that night she town, so I through (sic) (Resident #K's name) to paper and he also seen it away, but I wrote her deforget it, she is better				
	indicated "In con	clusion writer received				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155650		(X2) M A. BUII B. WIN	LDING	NSTRUCTION  00	(X3) DATE S COMPL 06/07/2	ETED	
NAME OF I			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIEF				RGINIA ST		
LINCOLI	NSHIRE HEALTH C	ARE CENTER		MERRII	LVILLE, IN46410		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	` `	ICY MUST BE PERCEDED BY FULL  LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG	<b>†</b>	alleged CNA (CNA #1's	+	IAG	Dia leiner,		DATE
		s to what occurred on the					
		#H's name) shower. In					
	1 '	NA #1's name) states that					
	`	(Resident #H's name)					
	1	H's name) became					
	, ` `	the transfer from the					
	, ,	e shower chair and she					
	states that she he	eld (Resident #H's name)					
		at she would not fall and					
	helped her to sit	in the chair. She also					
	stated that she as	sked (Resident #H's					
	name) about the	bilateral scars that are					
	located on her sh	noulders and (Resident					
	#H's name) state	d in return that she had					
	broken both of h	er arms before. She said					
	that she did take	the clothes from					
	I '	ame) and she explained					
	1	s name) that the clothes					
	1	vas the only reason why					
	1	hem, but (Resident #H's					
	1 '	ant her to and the nurse					
	1	ive them back if that's					
		l. (CNA #1's name) stated					
		iking more on the side on					
	` ′	ing the clean clothes that					
	· ·	ame) had just put on after					
	,	NA #1's name) also stated					
	`	sident #H's name) that					
	_	rked here as well and she					
	never do (sic) anything to jeopardize her job or any resident. She stated that she						
	1 "						
		ad by telling (Resident					
	#H's name) that.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650		<u> </u>	LDING	NSTRUCTION  00	(X3) DATE : COMPL 06/07/2	ETED	
NAME OF I	PROVIDER OR SUPPLIER		D. WII		ADDRESS, CITY, STATE, ZIP CODE		
				1	RGINIA ST		
	NSHIRE HEALTH C			MERRIL	LVILLE, IN46410		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		ic) abuse found to be					
	`	r alert and oriented					
		nterviewed on the same					
	hall and none of	them voiced any					
	complaints abou	t the care that they have					
	received. The C	NA (CNA #1's name) was					
	informed that she	e would no longer take					
	` ′	(Resident #H's name).					
	`	) received one on one					
		ng how residents may					
		An in-service was					
	1 ^	f the staff on abuse and					
	customer service	<b>)</b> ."					
	The gover letter	and fay varification naga					
		and fax verification page ormation had been faxed					
		Department of Health on					
	4/18/11.	Department of Health on					
	4/10/11.						
	The closed recor	d of Resident #H was					
	reviewed on 6/7/	'11 at 11:15 a.m. Her					
	diagnoses includ	led, but were not limited					
	_	hypertension, diabetes					
	mellitus, bipolar	, and chronic obstructive					
	pulmonary disea	se.					
	1	um Data Set Assessment,					
	· ·	idicated the resident was					
		could understand. She					
		ne Brief Interview of					
		hich indicated she was					
	cognitively intac	i.					
	Interview with the	ne DoN on 6/7/11 at 11:25					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155650		A. BUILDING	00		e survey pleted /2011	
	PROVIDER OR SUPPLIER		STREET. 8380 V	ADDRESS, CITY, STATE, ZIP C IRGINIA ST LLVILLE, IN46410	CODE	
	SUMMARY S (EACH DEFICIEN REGULATORY OR  a.m., indicated L told CNA #1 to g clothes back but shower room wh happened.  Interview with th 12:45 p.m., indic LPN #2, were aw the day of the ind indicated she wa allegation until s on 4/18/11. She #1 was not sent h the allegation wa suspended pendin 4/18/11. She the and LPN #2 had the allegation wa not know that wa the event of an all Interview with th p.m., indicated sl	ARE CENTER  TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)  PN #1 was the nurse who give Resident #H her she was not in the ere the incident  The DoN on 6/7/11 at ated both ,LPN #1 and ware of the allegations on eident. The DoN further is not made aware of the the returned to the facility also verified that CNA frome on 4/16/11, the day is made, but was the investigation on in indicated that LPN #1 not contacted her when is made because they did the what they were to do in ellegation of abuse.  The DoN on 6/7/11 at 2:30 the immediately informs or when she receives an	8380 V	IRGINIA ST	CODE  RRECTION SHOULD BE	(X5) COMPLETION DATE
	The federal tag re IN00090935. 3.1-28(a)	elates to Complaint				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155650		A. BUII		00	COMPL	ETED	
		155650	B. WIN			06/07/2	011
	PROVIDER OR SUPPLIER NSHIRE HEALTH CA	ARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 8380 VIRGINIA ST MERRILLVILLE, IN46410		RGINIA ST		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
F0282 SS=D	facility must be proin accordance with plan of care. Based on record facility failed to divere followed for reviewed with chorders in a sample administering art (Resident #D)  Findings included  The closed recorder reviewed on 6/6/resident's diagnost limited to, pneumon dementia ovariant  A physician order (7:30 p.m.), indicate on the many plant to and as needed for the many plant and as needed for the many plant and the molenty had been tear ointment twife for dry eyes.  Interview with the many plant and the many plant and the many plant and the molenty had been tear ointment twife for dry eyes.	d for Resident #D was 11 at 12:40 p.m. The ses included, but was not nonia, weakness, cancer, and anemia.  r, dated 5/14/11 at 1930 cated "artificial tears b both eyes twice daily	F0	0282	F282 _1. Unable to correct, Resident #D has been disch from the facility. 2. All residhave the potential to be affe by the alleged deficient practice. 3. All licensed staf be re-educated by 7-1-11 regarding transcription of ne orders on the Medication Administration Record and Treatment Administration Record. 4. The DON or designee will audit new orde least 5x/week to ensure ordere transcribed accurately of Medication Administration Rand Treatment Administration Rand Treatment Administration Rand Treatment Administration Rand Treatment Administration Record. The results of these findings will be reviewed in the Quality Assurance meeting monthly x3, then quarterly x ensure compliance. 5. Compliance date: July 7, 26	ents cted  f will  ers at ers  n the ecord  he  che	07/07/2011

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155650	A. BUI	LDING	00	COMPL 06/07/2	
		100000	B. WIN			00/07/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
LINCOLN	NSHIRE HEALTH CA	ARE CENTER			IRGINIA ST LLVILLE, IN46410		
	_				I		215
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		on 5/14/11 after the	1				
		. The prescription was					
	1 ^ -	5/16/11 since the					
	pharmacy was cl						
	pharmaey was er	0504 011 5/15/11.					
	Interview with L	PN #2 on 6/6/11 at 3:15					
		ne had taken care of					
	l * '	e indicated she knew					
		er for artificial tear					
		e she had written the					
		esident complained of her					
		LPN #2 opened the					
	1	and the tablet medications					
		or Resident #D. There					
	was no artificial						
		ne medication cart.					
	Interview with L	PN #1 on 6/7/11 at 9:02					
	a.m., indicated w	hen she passes					
		verifies the resident and					
	obtains their med	lications by looking at					
	the MARs to see	what medications were					
	ordered.						
	Interview with th	e Director of Nursing on					
	6/7/11 at 9:30 a.r	n., indicated she was not					
	aware of the orde	er for the artificial tears					
	not being given t	o Resident #D and the					
		written on the MARs.					
	She further indicate	ated that when a new					
	order for a medic	eation was obtained from					
	a physician the o	rder should be					
	transcribed on to	the MAR. She had					
	nothing to add as	to why the order had not					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL	TIPLE CO		(X3) DATE S COMPL		
AND PLAIN	OF CORRECTION	155650	A. BUILD	ING	00	06/07/2	
		100000	B. WING	CED FEET A	DDDEGG OWN GRAVE ZID GODE	00/01/2	011
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE RGINIA ST		
LINCOLN	ISHIRE HEALTH CA	ARE CENTER			LVILLE, IN46410		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCI)		DATE
		to the MAR or why LPN					
		she had not given the					
	medication to Re	sident #D.					
	This federal tag r IN00090935.	relates to complaint					
	3.1-35(g)(2)						
F0385 SS=D	a recommendation admitted to a facili	personally approve in writing n that an individual be ty. Each resident must care of a physician.					
	of each resident is and another physic	nsure that the medical care supervised by a physician; cian supervises the medical when their attending illable.					
	Based on record	review and interview, the	F03	85	F385 1. As stated in the 256		07/07/2011
	facility failed to	ensure a resident's			Resident #D was seen by the primary physician on 5/18/11		
	personal physicia	nn responded timely after			was admitted to the hospital.		
	• •	s were made to contact			All residents have the potenti		
	the physician rela	ated to a critically high			be affected by the alleged		
	sodium level for	1 of 5 residents reviewed			deficient practice. 3. All physicians have been contact	ted	
	for dehydration in	n the sample of 9.			regarding assignment of alter		
	(Resident #D and	l Physician #1)			physician coverage, andall		
	Findings included	d:			resident records will be upda to reflect the alternate physic assigned. Licensed staff will re-educated by 7-1-11 regard	ian be	
	The closed record	d for Resident #D was			the policy for physician	.5	
	reviewed on 6/6/	11 at 12:40 p.m. She was			notification and alternate		
	admitted to the fa	acility on 5/13/11. Her			physician notification if the	blo	
	diagnoses included, but was not limited			primary physician is unavaila or does not respond in a time			
		veakness, dementia,			manner. 4. The DON or	··· <b>y</b>	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155650	B. WIN		-	06/07/20	011
			D. WII		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				IRGINIA ST		
LINCOLN	NSHIRE HEALTH CA	ARE CENTER		1	LLVILLE, IN46410		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	,		(V5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	<b>.</b>	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
0	ovarian cancer, a	<u> </u>	-	0	designee will review lab resu	ılts	5.112
	ovarian cancer, a	ma anemia.		and change of condition progress			
		1 . 15/15/11			notes at least 5x/week to en		
	· ·	dated 5/17/11, indicated			the primary physician or alte	rnate	
		f 163. The reference			physician were notified and		
	"	47. The lab test indicated			responded in a timely		
		een verified and critical			manner. The results of these findings will be reviewed in the		
	values were calle	ed and faxed with read			Quality Assurance meeting		
	back to nurse (N	urse's name) at 11:06			monthly x3, then quarterly x2	2 to	
	a.m., on 5/17/11.	The BUN (blood urea			ensure compliance. 5.		
	nitrogen) was 43	with a reference range of			Compliance date: July 7, 20	)11	
		ottom of the lab result					
		hysician) and family					
	aware with a date						
	aware with a date	C 01 3/10/11.					
	A progress note	dated 5/17/11 at 11:10					
	1 1	critical lab value with					
	1 '						
		The Physician #1 was					
	1	fice was called with no					
	answer at this tin						
		pink. At 14:40 (2:40					
		#1 was called via cell					
	1 ^	s since the labs results					
	were received an	d there was no answer.					
	The staff was stil	ll waiting a return call					
	from Physician #	1. She took 240 CC					
	1	ers) of fluid with lunch					
	`	ater with medications					
	during the shift.						
	A progress note, dated 5/18/11 at 9:00						
	1 * 5						
	a.m., indicated staff attempted to call						
	Physician #1 via cell phone regarding the resident's elevated sodium level. There						
	was no answer.	Staff attempted to call					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
AND FLAN	OF CORRECTION	155650	A. BUIL		00	06/07/2	
		100000	B. WING		DDRESS, CITY, STATE, ZIP CODE	00/01/2	
NAME OF I	PROVIDER OR SUPPLIER				RGINIA ST		
LINCOL	NSHIRE HEALTH CA	ARE CENTER			LVILLE, IN46410		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1 -	fice and received					
	1	e and was instructed to					
		physician via cell phone.					
		.m.) Physician #1 was					
		itical sodium level. The					
	1 ^ *	red he would be in to visit					
		17:30 (5:30 p.m.),					
	1 -	s making rounds and a eceived to send the					
	resident to the no	ospital as a direct admit.					
	A doctor's progre	ess note, dated 5/18/11,					
	indicated the resi	dent was weak, ENT					
	(eyes, nose, throa	at) was very dry bucal					
	(mouth). Her so	dium was increase at 163					
	and her BUN wa	s increased at 43. She					
	had hypernatrem	ia (high sodium) and					
	needed to be adn	nitted to the hospital.					
	A History and Ph	nysician from the					
	hospital, dated 5/	/19/11, indicated, "84 y/o					
	(year old) f (fema	ale), nh (nursing home)					
	resident, I saw at	the nh yesterday found					
	to be clinically d	ehydrated with high NA					
	(sodium) of 160's	s and was directly					
	admitted to the h	ospital."					
	Physical exam: '	'She appears					
	well-developed a	and well-nourished. She					
	appears lethargic	. She appears cachectic.					
	She is uncooperative. She appears ill. No						
	distress."						
	Mouth/throat: "Mucous membranes are						
	dry."						
	Labs collected 5/	/18/11 at 2230 (10:30					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  D. NING			(X3) DATE SURVEY COMPLETED 06/07/2011	
NAME OF I		B. WING OU/01/2011  STREET ADDRESS, CITY, STATE, ZIP CODE  8380 VIRGINIA ST  MERRILLVILLE, IN46410					
LINCOLNSHIRE HEALTH CARE CENTER							
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES		ID PREF	137	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	- 1	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
ing	p.m.): BUN of 47 with a reference range		1710	-	·		DATE
	of 7-17 and a soc						
	reference range of						
	Assessment and						
	hospital problem						
	hypernatremia (h						
	dehydration, hyp						
	1 - 1	ial fibrillation, and					
	uterine cancer by	history."					
	The Nurse Consultant provided the						
	Administrative Physician Notification for						
		tion Policy on 6/6/11 at					
		olicy indicated, "The					
		oms, signs and laboratory					
	values should prompt immediate						
	notification of the physician. Immediate						
	implies that the physician should be						
	notified as soon as possible, either directly or by beeper/pager. If you do not obtain a						
	response from the physician, call the						
	designated alternate physician. If you still						
	do not receive a response, notify the						
	Director of Nursing for further						
	instruction."						
		ts: Sodium under 125 or					
	I -	is. Sodium under 123 of					
	over 150.						
	Interview with the	ne Director of Nursing on					
	6/7/11 at 9:30 a.r	_					
		s the Medical Director.					
	1 *	e facility had never had a					
		ntacting him until the					
	issue with Reside						

000577

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155650	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 06/07/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  8380 VIRGINIA ST  MERRILLVILLE, IN46410				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	over twenty-four physician was not speak to the Adm staff were to call be reached. She #D was only to be days before she whome. She had rule Interview with the 6/7/11 at 10:15 a Administrator had #2 was Physician indicated there he Physician #2 who labs were received	otified and she needed to ministrator to see who if Physician #1 could not also indicated Resident be in the facility for a few was to be discharged nothing further to offer.  The Director of Nursing on a.m., indicated the dinformed her Physician in #1 back up. She further and been no attempt to call the enthe critical sodium					